

Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence

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Abstract: During recent decades, a growing and preoccupying excess of medical interventions during childbirth, even in physiological and uncomplicated births, together with a concerning spread of abusive and disrespectful practices towards women during childbirth across the world, have been reported. Despite research and policy-making to address these problems, changing childbirth practices has proved to be difficult. We argue that the excessive rates of medical interventions and disrespect towards women during childbirth should be analysed as a consequence of structural violence, and that the concept of obstetric violence, as it is being used in Latin American childbirth activism and legal documents, might prove to be a useful tool for addressing structural violence in maternity care such as high intervention rates, non-consented care, disrespect and other abusive practices. © 2016 Reproductive Health Matters. Published by Elsevier BV. All rights reserved.

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Introduction

The World Health Organization (WHO) has shown concern about the excessive medicalisation of birth since 1985, when it recommended the appropriate use of technologies for birth, urging administrators and health personnel to review protocols and continuously investigate the relevance of certain practices, while promoting respect for women's autonomy and perspective when making judgements.¹ Yet, since then, the rates of non-medically justified obstetric interventions have increased in middle- and high-income countries without dramatic improvement in perinatal and maternal mortality and morbidity. Moreover, there is increasing concern about the iatrogenic effects of obstetric

interventions in women who do not have a clinical need, thereby putting "normal" birth firmly on the agenda for the 21st century.²

It has been suggested that unnecessary interventions could be reduced through the clarification of and adherence to the basic legal principle of informed consent,³ including the right to refuse medical interventions.⁴ The principle of informed consent is not new, with United States court papers from the 19th century advocating for the right of each person, in particular women, to have their dignity respected and the unlawful touch of a stranger being deemed an assault or trespass.⁵ More recently, the United Nations Educational, Scientific and Cultural Organisation (UNESCO), through its Universal

Declaration of Bioethics and Human Rights, recognised that “*health does not depend solely on scientific and technological research developments, but also on psychosocial and cultural factors.*” Furthermore, it stressed that autonomy and the right to make decisions should be respected.³

However, it is necessary to acknowledge the flaws in the assumption that women fully understand their options and are always able to make free, adequate choices about the nature of medical care. This question was strongly raised in 1993, with the *Changing Childbirth* report, calling for women-centred care and stressing the importance of choice during childbirth.⁶ Further reports have continued to highlight that women should be the focus of maternity care, being able to make decisions based on their needs, having fully discussed matters with the professionals involved.² But women worldwide continue to be excluded from participating in the design and evaluation of maternity care. Despite being invited to develop birth plans and exercise autonomy, the range of choices presented to women by the medical profession may be limited.^{7,8} Furthermore, the available healthcare system might not provide appropriate, evidence-based care.

These limitations seem particularly evident in countries that have legislation making it illegal or close to impossible for healthcare providers to offer home birth services or midwifery-led birth centres. Even in settings where out-of-hospital births are not illegal, planning and experiencing one can be a challenging task for families and professionals. The existing evidence that many medical interventions are overused, while structural and social interventions are often underused, has had limited impact on practice.⁹

Non-evidence-based practices

It is a fact that in many countries, including high-income ones, the best available evidence is not always used to inform maternity care; rather practice is driven by local beliefs about childbirth, and professional or organisational cultures. This is particularly visible when taking into account the variations in intervention rates between and within countries, and even between institutions and health practitioners in the same country. As an

example, we can look at the two most widespread interventions in childbirth, which are surgical in nature and are often used in healthy women with little or no justification: episiotomy and caesarean section.

Restricted use of episiotomy is associated with better outcomes when compared with routine use.¹⁰ Yet, episiotomy rates vary immensely in European hospitals with rates as high as 70% in Cyprus, Poland and Portugal, 43–58% in Wallonia, Flanders, the Czech Republic, and Spain, and 16–36% in Wales, Scotland, Finland, Estonia, France, Switzerland, Germany, Malta, Slovenia, Luxembourg, Brussels, Latvia, and England.¹¹ In 2010, the lowest reported rates of episiotomy were in Denmark (4.9%), Sweden (6.6%), and Iceland (7.2%).¹¹ However, in some countries, first time mothers are routinely given episiotomies,¹¹ despite the lack of evidence to support this practice.¹⁰ A hospital-based descriptive study which analysed data from 122 hospitals in 16 Latin American countries between 1995 and 1998 showed that 87% of the hospitals had episiotomy rates higher than 80% and 66% had rates higher than 90%,¹² and a study in Mexico carried out in 2005–2006 reported episiotomy rates of 84%.¹³

The use of unnecessary caesarean sections is also well documented. The World Health Organization (WHO) confirms that caesarean section rates higher than 10% are not associated with lower maternal and newborn mortality on a population level.¹⁴ Nevertheless, according to the Organisation for Economic Co-operation and Development (OECD) the Nordic countries (Iceland, Finland, Sweden and Norway), Israel and the Netherlands had the lowest caesarean section rates in 2013, ranging from 15% to 16.5% of all live births; while Turkey, Mexico and Chile had the highest, with rates ranging from 45% to 50%.¹⁵ Latin America is the region where the highest rates of caesarean sections in the world are concentrated, with several countries above 40%,¹⁵ and Brazil leading the trend with 54%.¹⁶

If the huge variations in caesarean section between countries raise questions about the appropriateness of interventions that may not be medically required, the differential rates across regions and hospitals within the same country can be even more alarming.¹⁵ In Canada, Finland, Germany and Switzerland, caesarean section rates vary by up to two times across regions, and by more than three times across Spain and six times in different regions of Italy.¹⁷

Around the globe, caesarean section rates tend to be higher in private settings and for women with higher economic status. In Chile, caesarean section rates were 39% in public health and 72% in private health settings in 2012, with big variations within systems.¹⁸ Even more interestingly, in public hospitals with the same staff of obstetricians and midwives, a woman who pays a bonus to access private care will triple her chance of having a caesarean section.¹⁹

The variations in caesarean section rates are linked to supply and demand related factors,¹⁷ and most directly to economic factors. As stated in an article in *The Economist* in 2015, the global rise of caesarean sections is being driven not by medical necessity but by growing wealth and perverse financial incentives for doctors.²⁰ Malpractice liability concerns are high among the main non-medical factors that are influencing excessive interventions.^{8,15} Even when women are requesting caesarean sections, questions should be asked about the quality of the information they have received, acknowledging that only a minority of women in a wide variety of countries express a preference for caesarean delivery.²¹

Disrespect and abuse during childbirth

The concerns about non-evidence-based interventions are one of the reasons for the growing international attention and debate on the problem of disrespect and abuse of women during childbirth. In the last years, there have been several attempts to structure the discussion on the topic. In 2010, Bowser and Hill proposed seven categories to group disrespect during childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on patient attributes, abandonment of care, and detention in facilities.²² Freedman and colleagues argued that those categories lacked a definition in terms of the characteristics of healthcare provider behaviour, facility conditions or other factors that could be constructed as disrespectful and abusive.²³ They proposed a model to assess the individual, structural, and policy level interactions that shape the problem, and defined disrespect and abuse in childbirth as the “*interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified*”, acknowledging its links with the wider

social dynamics of inequality and uneven power between groups.²³

Amid the growing debate, in 2014 the World Health Organization released a powerful statement on *Prevention and elimination of disrespect and abuse during facility-based childbirth*, where the right of every woman to access dignified and respectful health care was highlighted.²⁴ A systematic review by Bohren and colleagues followed on mistreatment of women during childbirth, presenting a new typology of mistreatment organised in seven themes: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints.²⁵ The authors discuss how mistreatment can occur at the level of interaction between the woman and provider, as well as through systemic failures at the health facility and health system levels.²⁵

Jewkes and Penn-Kekana argue that clear parallels between the mistreatment of women in childbirth and violence against women (more broadly) can be drawn from Bohren and colleagues' systematic review, highlighting that the “*essential feature of violence against women is that it stems from structural gender inequality*.”²⁶ A recent editorial from the *International Journal of Gynecology and Obstetrics*, entitled *The unfinished agenda of women's reproductive health*,²⁷ states:

“As the clinical indicators of maternal health improve, we begin to focus more on quality of care and this has raised the gender-related issue of disrespect and abuse that women in labor tend to suffer at the hands of both male and female care givers.”

In fact, gender has been central to the conceptualisation of the term obstetric violence. Although it has been often used as a synonym for disrespect, abuse and mistreatment during childbirth, we argue that obstetric violence has the potential for addressing the structural dimensions of violence within the multiple forms of disrespect and abuse.

Obstetric violence as violence against women

Despite being cited in records from the 19th century,²⁸ the concept of obstetric violence has only

recently gained popularity among childbirth activists' movements in Latin America. Brazil pioneered the discussions in 1993 with the foundation of the Network for the Humanization of Labour and Birth (ReHuNa), which recognised the circumstances of violence and harassment in which care happens.²⁹ A landmark event for the region was the First International Conference for the Humanization of Birth, held in Brazil in 2000, where a cohesive group of Latin American activists, researchers and health professionals gathered in response to the high rates of childbirth interventions and growing recognition of abuses toward birthing women. The RELACAHUPAN (Latin American and Caribbean Network for the Humanization of Childbirth) was founded in this meeting, leading the debate on women's right to respected childbirth within the region.³⁰

In 2007, Venezuela became the first country to formally define the concept of obstetric violence through the *Organic Law on the Right of Women to a Life Free of Violence*,³¹ where obstetric violence is codified as one of the 19 kinds of punishable forms of violence against women. In article 15, obstetric violence is described as:

"The appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanising treatment, an abuse of medicalisation and pathologisation of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life." (Authors' translation)

Furthermore, article 51 specifies the acts that constitute obstetric violence: untimely and ineffective attention to obstetric emergencies; forcing the woman to give birth in a supine position when the necessary means to perform a vertical delivery are available; impeding early attachment of the child with his/her mother without a medical cause; altering the natural process of low-risk labour and birth by using augmentation techniques, and performing caesarean sections when natural childbirth is possible, without obtaining the voluntary, expressed, and informed consent of the woman.³¹

The concept of obstetric violence has been promoted by civil society groups across borders. Argentina³² and some states in Mexico³³ have also framed obstetric violence within the broader legislations concerning gender inequalities and violence, stressing the unequal position of

women – and pregnant women in particular – in the healthcare system and in society. Since 2014, five Obstetric Violence Observatories led by civil society groups have been founded, in Chile, Spain, Argentina, Colombia and France, and in March 2016 they released a common statement declaring that obstetric violence has been one of the most invisible and naturalised forms of violence against women and that it constitutes a serious violation of human rights.³⁴ This institutionalisation of the concept is an acknowledgement of the critiques of the medicalisation of maternity care settings and the violation of sexual and reproductive health rights.³⁵

The definition of obstetric violence, besides focusing on dehumanised treatment, highlights its obstetrical dimension, from the roots of this medical speciality to contemporary education and structures of power.^{36,37} It frames the discussion of abuse and disrespect within the broader field of structural inequalities and violence against women.

Making structural violence visible

It is of the utmost importance to analyse obstetric violence separately from other forms of medical violence, acknowledging the differences between the mistreatment of women in childbirth and the overall mistreatment of patients. Obstetric violence has particular features demanding a distinct analysis: it is a feminist issue, a case of gender violence; labouring women are generally healthy and not pathological; and labour and birth can be framed as sexual events, with obstetric violence being frequently experienced and interpreted as rape.³⁸ Biomedicine is a social and cultural system, a complex historical construction with a consistent set of internal beliefs, rules and practices,³⁹ which responds to and reproduces gender ideologies across health professions, the legal system and the state. However, the biomedical culture has been overlooked. The power of biomedicine in health systems is a common but unnamed element, and its hegemony seems to erase the need to report its existence.

These discrete mechanisms can be analysed as forms of structural violence, invisible manifestations of violence that are built into the fabric of society, producing and reproducing social inequalities across groups.⁴⁰ In fact, obstetric violence has been placed on the feminist and public policy agendas, but it has

been mainly overlooked by professionals and institutions.²⁹ Keeping in mind the discussed limits of informed consent, and that women often have little choice but to acquiesce to the power of professionals,⁷ explicit and deliberate forms of violence and mistreatment in maternity should not be discussed regardless of their context. Centring the debate on individual malpractices has the potential to generate unproductive hostility towards the discussion of disrespect and abuse in childbirth, especially among health professionals, which is why Jewkes and Penn-Kekana argue there is a need to avoid “*blaming the health workers as a group*.”²⁶ One of the reasons why the term obstetric violence is not more widespread is that health professionals resist the use of the concept of violence, which is contrary to their ethos. As Diniz and colleagues explain, this made ReHuNa in Brazil deliberately decide not to talk openly about violence during the nineties, favouring terms like “humanising childbirth” and “promoting the human rights of women.” Nonetheless, the same authors acknowledge that significant changes have occurred after the debate started to be framed as a matter of violence and human rights violation.²⁹

This reinforces the need for a broader analysis, centred in the cultural and social dimensions embedded in the phenomenon of obstetric violence, which can allow a shift from the limited focus on victims (women) and victimisers (health professionals), to the acknowledgement of the ubiquitous socialisation of men and women into naturalised, and thus invisible, forms of violence and power dynamics between groups. The power structures embedded and reproduced in biomedicine should be made visible. The hidden curriculum in health professionals’ education and practice should be included in the international agenda on obstetric violence, where the acceptance of norms, corporate discipline and punishment plays a central role,^{41–43} while the emotional dimensions of care are neglected.⁴⁴ The poor working conditions of many health professionals should also be framed as forms of disrespect and abuse, as well as the consequences of being socialised within – and driven to exercise – violence. Evidence shows that health personnel exposed to violence in childbirth may suffer secondary traumatic stress or compassion fatigue, understood as a secondary exposure to extreme traumatic stressors similar to those experienced by patients with primary exposure.⁴⁵

The contributions of the social sciences

Social scientists have produced a considerable body of research on the medical management of childbirth as a reflex of asymmetric gender powers and as a process where female bodies are objectified. In the dawn of obstetrics, the masculine medical profession regarded male physiognomy and physiology as the norm, which had particular repercussions in the establishment of this medical specialty, in the professionalisation of midwives,^{36,46,47} and in women’s health.^{48,49} As a consequence, the female body and its natural processes were – and continue to be – portrayed as abnormalities, diseases or deviances. Professional and lay discourses referring to the *diagnosis* of pregnancy, to pregnancy *symptoms* and to the pregnant woman’s *return to the normal state* after birth are some of several discrete markers of the male normalisation.⁴⁶

Former philosophical and social sciences perspectives have positioned medicalised childbirth within the scope of objective and systematic violence. Foucault describes the emergence of the control of childbirth by normalising institutions, such as the church, the state and, later, medicine, and how the female body was first objectified and studied through its differences and deviances from the male norm.^{43,50} Today, obstetric violence can indeed be seen as a reflection of how female bodies in labour are perceived as potentially opposing to femininity – violence is thus necessary to dominate them, restoring their “inherent” feminine submission and passivity. It becomes a tool for disciplining the undisciplined body in labour, in order to re-feminise and re-objectify the body.³⁸ In fact, despite the common references to care and femininity, childbirth at the hospital is frequently depicted through a chain of patriarchal forces – the participants trying to coach and control the labouring women, and the hospital trying to control both members of the couple.⁵¹

Male symbolic domination and female symbolic submission can be performed not only through force, but also, and mainly, through these discrete mechanisms, completely naturalised within the normal order of things.⁵² Although embedded in society, they are laboriously reproduced in everyday life. In the line of Bourdieu’s arguments, obstetric violence must be approached as more than the mere act of mistreatment – it is surrounded by

socially constructed symbolic meanings.⁵² It may imply the consent of both dominant and dominated, within a social relationship where the knowledge shared amongst all actors only allows framing the violence itself as if it were a natural, expected and accepted part of life. In such a context, violence is not only accepted, but also reproduced and reinforced by all actors involved: women, families, professionals, and decision-makers. As such, obstetric violence can be remarkably functional, reinforcing a biased gender narrative in sexual and reproductive health care, and structuring maternity care.

Research, policies and guidelines, professional and academic education, and social movements failing to address the structural dimensions are deemed to tackle only the micro- and meso-level *symptoms*, but not the macro-level *causes* of these forms of violence.⁴⁰ Obstetric violence is a useful concept that can help us better understand those macro-level causes, and has the potential to reframe the problem of overused interventions, non-consented care and abusive practices, and to trigger new calls for action. Having its origins in grassroots movements, the concept should be central to the discussion as it represents the voices of women. There is, however, a need to develop a more accurate definition of the concept to place *the appropriation of women's body and reproductive processes*, as defined in Venezuelan law,³¹ in health systems more than in health personnel, stressing that this is a phenomenon that is inherent to the structural dimensions of maternity care provision.

Conclusion

Moving beyond the focus on the interactional dimensions of disrespect and abuse in childbirth makes way for an integrated perspective over this global issue. A dynamic dialogue between health and social sciences, mobilising the existing knowledge about the structural dimensions of obstetric violence and recognising this phenomenon as a particular form of violence against women, naturalised within health care systems, can set the ground for structural improvements in maternity care. As such, the concept of obstetric violence can be used as a tool to potentially reframe the international agenda on disrespect and abuse in childbirth, and to contribute to change in maternity care worldwide.

Recommendations for action

Obstetric violence is a multi-faceted complex phenomenon which requires a multidimensional approach and contributions from different disciplines. In order to advance the debate and effect change, it is vital that there are international and national initiatives to address structural violence in childbirth.

At the legislative and economic level each country needs to develop relevant legislation that can drive organisations to address obstetric violence, including the fallacy of informed choice and consent, and the provision of non-evidenced-based care. In particular, perverse financial incentives need to be addressed. Legal barriers for access to maternity care services including out of hospital services must be identified and tackled. Furthermore, the gap between perceived barriers and legal barriers must be addressed. The identification of successful initiatives that have addressed obstetric violence and effected lasting change may help to identify best practice and provide a road map for other maternity services and countries to follow.

At the organisational level we suggest mandatory/statutory involvement of women's groups and members of civil society movements in decisions about maternity care including the design, planning, delivery and evaluation of care. This could be achieved through introducing similar legislation and monitoring of Personal and Public Involvement (PPI) in Health Care such as in the United Kingdom⁵³ and other EU countries. If maternity care providers are to truly engage and involve women and their families in decisions, it is important to explore their understanding and experiences of obstetric violence.

Healthcare authorities should ensure that all women have access to evidence-based and unbiased information about interventions. Published and oral information should be evaluated on a regular basis. We furthermore suggest implementation of reporting systems that allow women and health professionals to report instances of obstetric violence and to assess the complete range of medical interventions during childbirth. Maternity units should be supervised and certified when giving the appropriate standards of care, as has been proposed in the 2015 FIGO Guidelines for Mother-baby friendly birthing facilities.⁵⁴

At the educational level, the principles of human rights in childbirth and the

discussion on obstetric violence and its impact on professionals, mothers, babies, and their families should be included in the curriculum in all relevant educational institutions (legal, medical, midwifery, nursing, and others), stressing its gender-related dimensions.²⁹ This is a necessary step because many aspects of obstetric violence are not questioned, they are taken for granted and naturalised.

Finally, *at the research level* we identify a need for robust, interdisciplinary, cross-national research that assists decision makers, maternity care providers, women and families who access maternity services to better understand, define and challenge this phenomenon.

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Résumé

Ces dernières décennies, un excès croissant et préoccupant d'interventions médicales pendant l'accouchement, même dans des naissances physiologiques et sans complications, parallèlement à une multiplication de pratiques violentes et irrespectueuses à l'égard des femmes pendant l'accouchement, a été rapporté de par le monde. En dépit de recherches et de décisions politiques pour corriger ces problèmes, il s'est révélé difficile de changer les pratiques obstétricales. Nous avançons que le taux excessif d'interventions médicales et le manque de respect à l'égard des parturientes devraient être analysés comme conséquence de la violence structurelle et que le concept de violence obstétricale, tel qu'il est utilisé dans l'activisme latino-américain de l'accouchement et dans les documents juridiques, peut être un outil précieux pour s'attaquer à la violence structurelle dans les soins maternels, comme les taux élevés d'intervention, les soins non consentis, le manque de respect et d'autres abus.

Resumen

Durante décadas recientes, se ha reportado un creciente y preocupante exceso de intervenciones médicas durante el parto, incluso en partos fisiológicos sin complicaciones, junto con un preocupante aumento de prácticas abusivas e irrespetuosas hacia las mujeres durante el parto en todo el mundo. A pesar de investigaciones y políticas formuladas para tratar estos problemas, ha resultado difícil cambiar las prácticas relacionadas con el parto. Argumentamos que las tasas excesivas de intervenciones médicas y la falta de respeto hacia las mujeres durante el parto deben analizarse como una consecuencia de la violencia estructural, y que el concepto de violencia obstétrica, tal como se utiliza en el activismo relacionado con el parto y en documentos jurídicos en Latinoamérica, podría ser una herramienta útil para abordar la violencia estructural en la atención materna, tales como altas tasas de intervención, cuidados sin consentimiento, falta de respeto y otras prácticas abusivas.